Continuing Education Module

Position Paper: Promoting, Supporting, and Protecting Normal Birth

Lamaze International

ABSTRACT

This updated position paper contrasts medical management of labor and birth with the normal physiology of birth and describes the care practices that support and facilitate the normal process. Lamaze International urges care providers to adopt these care practices as the standard of care, unless evidence-based medical reasons dictate otherwise. The roles of Lamaze-certified childbirth educators and the Lamaze Institute for Normal Birth in protecting, preserving, and promoting normal birth are described.

Journal of Perinatal Education, *16*(3), 11–15, doi: 10.1624/105812407X217084
Keywords: normal birth, childbirth education, position paper

Most recent update: May 2007

Birth in the 21st century is characterized by interventions designed to start, continue, and end labor by routine medical management that "expects trouble" rather than allows the normal, natural, physiologic process of birth to unfold. Against this backdrop of medical management of birth, more than 30% of all women undergo cesarean surgery (Hamilton, Martin, & Ventura, 2006), including approximately 24% of low-risk women giving birth for the first time (Menacker, 2005). Evidence suggests that medical management of birth contributes to these high rates, increases the likelihood of injury to both mothers and babies, and does not improve outcomes (Coalition for Improving Maternity Services, 2007; Enkin et al., 2000).

Despite the clear and consistent evidence, the *Listening to Mothers II* survey of women who gave birth in the United States in 2005 reported that 41% experienced medical induction of labor and another 47% received synthetic oxytocin to stimulate their labors to move more quickly (Declercq, Sakala, Corry, & Applebaum, 2006). More than three quarters of the women in the survey used epidural anesthesia during labor, and 7% of the women experienced instrumental vaginal births. Ninety-four percent of the surveyed women had electronic fetal monitoring (EFM) rather than intermittent auscultation, although the routine use of EFM increases the cesarean rate with no change in infant mortality or morbidity in normal labors (Enkin et al., 2000; Goer, Leslie, & Romano, 2007; Thacker, Stroup, & Chang, 2003).

These statistics are alarming, because there is no research demonstrating that medical management of labor and birth is safer than respecting and facilitating normal physiology. In fact, an increasing

Lamaze International has created an independent study based on this article. Please visit the Lamaze Web site (www.lamaze.org) for detailed instructions regarding completion and submission of this independent study for Lamaze contact hours.

THE SIX CARE PRACTICES THAT SUPPORT NORMAL BIRTH

Care Practice #1: Labor Begins on Its Own
Care Practice #2: Freedom of Movement Throughout Labor
Care Practice #3: Continuous Labor Support
Care Practice #4: No Routine Interventions
Care Practice #5: Spontaneous Pushing in Upright or Gravity-Neutral Positions
Care Practice #6: No Separation of Mother and Baby, With Unlimited Opportunities for Breastfeeding

For more resources and to download a copy of each updated care practice paper, visit the Lamaze Institute for Normal Birth link at Lamaze International's Web site (www.lamaze.org).

amount of research indicates that routine medical management of birth increases the risks for mother and baby without improving outcome (Coalition for Improving Maternity Services, 2007; Enkin et al., 2000). Despite the evidence of its risks, medically managed birth, or "expecting trouble," is the norm.

Lamaze International believes that the safety of birth is enhanced not by "expecting trouble," but by respecting and facilitating the normal, natural, physiologic processes of labor and birth.

THE NORMAL PHYSIOLOGY OF LABOR AND BIRTH AND THE IMPORTANT ROLE OF CONFIDENCE

The normal, natural, physiologic process of birth involves a sequence of interacting events: the softening and opening of the cervix and the rotation and descent of the baby through the maternal pelvis. It is exquisitely orchestrated by maternal and fetal hormones and facilitated by the movement of the mother and her ability to actively work with her labor. Being able to actively work with her labor helps her tolerate increasing levels of oxytocin, and this ultimately ensures not only that labor will progress, but that she will benefit from the release of endorphins, nature's narcotic. Her confidence and her ability to work with her body rather than fight the contractions help keep stress hormones low until they become helpful much later in labor. If labor is allowed to progress normally, her baby is born with high levels of catecholamines and is bright, alert, and ready to nurse soon after birth. The high levels of maternal endorphins, oxytocin, and catecholamines at birth facilitate the separation of the placenta, decrease the risk of postpartum hemorrhage, and ensure that she will be ready and eager to respond to and nurse her baby. Interfering in the sequencing of any of these events creates the potential for problems. It makes sense that any interference with the natural process of childbirth should be shown to do more good than harm.

Lamaze International encourages women to be confident in their ability to give birth. Lamaze International further encourages health-care providers to understand and trust the normal, natural process of birth and to promote, support, and protect women's confidence and their ability to give birth without medical intervention.

THE SIX CARE PRACTICES THAT SUPPORT NORMAL BIRTH

Lamaze International has identified six care practices, adapted from the World Health Organization (Chalmers & Porter, 2001), that promote, support, and protect normal birth. Research has demonstrated the benefits of each of these practices (Coalition for Improving Maternity Services, 2007; Enkin et al., 2000). The Lamaze Institute for Normal Birth Care Practice Papers provide more information about the evidence that supports each of the care practices, as described below.

Care Practice #1: Labor Begins on Its Own

Labor begins on its own when all of the complex, interacting components required for the normal, natural process of birth are in place. When care providers artificially initiate the process, or try to alter it in any way, they override normal physiology and expose the woman and her baby to risks. It is not surprising that labors induced for nonmedical reasons are more likely than naturally occurring labors to result in problems (Goer et al., 2007). Suspecting a large baby is not an indication for induction (Chauhan et al., 2005; Irion & Boulvain, 2003). Induction of labor is a major contributor to the overall increase in cesarean section rates (Main et al., 2006).

Care Practice #2: Freedom of Movement Throughout Labor

Women who are free to move during labor and birth are better able to actively work with their labors. In doing so, women are more able to tolerate the increasingly painful contractions that accompany rising levels of oxytocin. Women then ultimately benefit from the resulting endorphin release. Women's response, with position change and other movement, helps the baby to rotate and descend through the pelvis, protecting the birth canal (Enkin

et al., 2000). There is no research demonstrating benefits of restricting movement in labor (Storton, 2007a).

Care Practice #3: Continuous Labor Support

Across time and cultures, women have been supported, most often by other women, as they labor and birth. Current research supports the benefit of this ancient practice. Women with continuous emotional and physical support during labor and birth remain confident, are more able to actively work with their labors, and are less likely to require medication or medical interventions (Hodnett, Gates, Hofmeyr, & Sakala, 2003; Simkin & O'Hara, 2002).

Care Practice #4: No Routine Interventions

Any intervention in labor or birth has possible benefits and risks. When interventions are used in normal labor and birth, women and babies are not likely to experience benefits of the interventions, but are exposed to the risks. Each intervention sets the stage for more, with the result a literal cascade of interventions. ''Expecting trouble'' in fact creates trouble. To reduce the possibility that the normal, natural, physiologic process of birth will be disrupted, there should be clear medical indication for the use of any intervention (Enkin et al., 2000; Goer et al., 2007).

Care Practice #5: Spontaneous Pushing in Upright or Gravity-Neutral Positions

In a recent survey, 57% of women in the United States gave birth on their backs (Declercq et al., 2006), although research suggests that it is a harmful practice. Movement and upright and gravity-neutral (such as side-lying and hands-and-knees) postures enlarge pelvic diameters, allow gravity to assist in rotation and descent of the baby, and protect the birth canal and the baby during rotation and descent. The upright posture during second-stage (pushing) labor decreases the incidence of severe pain, shortens the duration of second stage, and decreases the incidence of abnormal fetal heart rate patterns (Gupta, Hofmeyr, & Smyth, 2004; Storton, 2007a). When a woman pushes the way her natural urges tell her to (spontaneous pushing), she has the best chance of preventing tears and muscle weakness in her pelvis after the birth (Roberts & Hanson, 2007). Allowing women to find the positions that are most comfortable for them, encouraging them to push in response to what they are feeling, and avoiding time restrictions on second stage (if mother and baby are doing well) are all beneficial, according to current evidence (Enkin et al., 2000; Roberts & Hanson, 2007).

Care Practice #6: No Separation of Mother and Baby, With Unlimited Opportunities for Breastfeeding

Babies kept skin-to-skin with their mothers are able to maintain their temperatures and to display more regular respirations and more stable heart rates (Bystrova et al., 2003; Christensson et al., 1992; Enkin et al., 2000). The touch and movement of the baby stimulate oxytocin release in the mother (Matthiesen, Ransjo-Arvidson, Nissen, & Uvnas-Moberg, 2001), facilitating separation and delivery of the placenta, decreasing the risk of postpartum hemorrhage, and facilitating breastfeeding. Babies kept with their mothers are able to find the breast and self-attach, whereas separation for even a short time disturbs the sequence of events (Righard & Alade, 1990). Although the most effective way to ensure the safe transition of the baby is to keep the mother and baby together in close physical contact (Enkin et al., 2000; Storton, 2007b), only 34% of babies remain in their mothers' arms in the first hour after birth (Declercq et al., 2006).

Lamaze International recommends that care providers, hospitals, and birth centers adopt these six practices as standards of care and encourages women and their families to choose care providers and birth settings that employ care practices that promote, support, and protect normal birth.

LAMAZE CHILDBIRTH EDUCATION

The goal of Lamaze preparation for birth is that women have confidence in their inherent ability to give birth with the freedom and support they need to give birth normally. In Lamaze childbirth education classes, women learn to understand and trust normal, natural, physiologic birth and are encouraged to work actively with labor and to plan carefully for the freedom and support they will need. Women are encouraged to let labor start on its own and to keep their babies with them from the moment of birth. Lamaze International encourages all childbearing women to attend childbirth classes that promote the six care practices described above and that increase their confidence in their ability to give birth normally.

LAMAZE INSTITUTE FOR NORMAL BIRTH

The mission of Lamaze International is to promote, support, and protect normal birth through education

and advocacy. The Lamaze Institute for Normal Birth was launched to support initiatives that provide credible, relevant, and useful information about normal birth to new and expectant parents and childbirth professionals. It is a vehicle for advocacy, information, and coalition-building to advance the Lamaze mission. Lamaze International has a strong history of collaboration with organizations and individuals sharing our mission, and we join them now in the worldwide effort to promote, support, and protect normal birth.

ACKNOWLEDGEMENTS

This position paper and accompanying six care practice papers were originally developed in 2003 by Lamaze® International and published in 2004 in *The Journal of Perinatal Education 13*(2) issue. The following members of the Lamaze International Education Council contributed to and reviewed the first edition of the position paper:

- Judith Lothian, RN, PhD, LCCE, FACCE (principal author)
- Debby Amis, RN, BSN, CD (DONA), LCCE, FACCE
- Diana Chiaverini, RN, MEd, LCCE, FACCE
- Jeannette Crenshaw, RN, MSN, IBCLC, LCCE, FACCE
- Joyce DiFranco, RN, BSN, LCCE, FACCE
- Caroline Donahue, RN, MA, LCCE, FACCE
- Michele Ondeck, RN, MEd, IBCLC, LCCE, FACCE

The updated (May 2007) edition of *Position Paper: Promoting, Supporting, and Protecting Normal Birth* was edited by Amy M. Romano, MSN, CNM.

REFERENCES

Bystrova, K., Widstom, A. M., Matthiesen, A. S., Ransjo-Arvidson, A. B., Welles-Nystrom, B., Wassberg, C., et al. (2003). Skin-to-skin contact may reduce negative consequences of "the stress of being born": A study on temperature in newborn infants, subjected to different ward routines in St. Petersburg. *Acta Paediatrica, 92*(3), 320–326.

Chalmers, B., & Porter, R. (2001). Assessing effective care in normal birth: The Bologna Score. *Birth, 28*(2), 79–83.

Chauhan, S. P., Grobman, W. A., Gherman, R. A., Chauhan, V. B., Chang, G., Magann, E. F., et al. (2005). Suspicion and treatment of the macrosomic fetus: A review. *American Journal of Obstetrics and Gynecology, 193*(2), 332–346.

Christensson, K., Siles, C., Moreno, L., Belaustequi, A., De La Fuente, P., Lagercrantz, H., et al. (1992). Temperature, metabolic adaptation and crying in healthy full-term newborns cared for skin-to-skin or in a cot. *Acta Paediatrica, 81*(6–7), 488–493.

Coalition for Improving Maternity Services. (2007). Evidence basis for the ten steps of mother-friendly care [Supplement issue]. *The Journal of Perinatal Education, 16*(Suppl. 1).

Declercq, E. R., Sakala, C., Corry, M. P., & Applebaum, S. (2006). *Listening to mothers II: Report of the second national U.S. survey of women's childbearing experiences.* New York: Childbirth Connection.

Enkin, M., Keirse, M., Neilson, J., Crowther, C., Duley, L., Hodnett, E., et al. (2000). *A guide to effective care in pregnancy and childbirth.* New York: Oxford University Press.

Goer, H., Leslie, M. S., & Romano, A. (2007). The Coalition for Improving Maternity Services: Evidence basis for the ten steps of mother-friendly care. Step 6: Does not routinely employ practices, procedures unsupported by scientific evidence. *The Journal of Perinatal Education, 16*(Suppl. 1), 32S 64S.

Gupta, J. K., Hofmeyr, G. J., & Smyth, R. (2004). Position in the second stage of labour for women without epidural anaesthesia. *Cochrane Database of Systematic Reviews, 4.* Art. No.: CD002006.

Hamilton, B. E., Martin, J. A., & Ventura, S. J. (2006). Births: Preliminary data for 2005. *National Vital Statistics Report, 55*(11), 1–19.

Hodnett, E. D., Gates, S., Hofmeyr, G. J., & Sakala, C. (2003). Continuous support for women during childbirth. *Cochrane Database of Systematic Reviews, 3.* Art. No.: CD003766. (Full text of this review available at no charge on the Childbirth Connection Web site at www.childbirthconnection.org/pdfs/continuous_support.pdf)

Irion, O., & Boulvain, M. (2003). Induction of labour for suspected fetal macrosomia. In *The Cochrane Library, issue 3*. Oxford: Update Software.

Lamaze International. (2001). *Position paper: Lamaze for the 21st century*. Washington, DC: Author. Also, retrieved May 31, 2007, from http://www.lamaze.org/Portals/0/Policies/3_Lamaze21stCentury.pdf

Main, E. K., Moore, D., Farrell, B., Schimmel, L. D., Altman, R. J., Abrahams, C., et al. (2006). Is there a useful cesarean birth measure? Assessment of the nulliparous term singleton vertex cesarean birth rate as a tool for obstetric quality improvement. *American Journal of Obstetrics & Gynecology, 194*(6), 1644–1651; discussion 1651–1642.

Matthiesen, A., Ransjo-Arvidson, A., Nissen, E., & Uvnas-Moberg, K. (2001). Postpartum maternal oxytocin release by newborns: Effects of infant hand massage and sucking. *Birth, 28*(1), 13–19.

Menacker, F. (2005). Trends in cesarean rates for first births and repeat cesarean rates for low-risk women: United States, 1990–2003. *National Vital Statistics Report, 54*(4), 1–8.

Righard, L., & Alade, M. O. (1990). Effect of delivery room routines on success of first breastfeed. *Lancet, 336*(8723), 1105–1107.

Roberts, J., & Hanson, L. (2007). Best practices in second stage labor care: Maternal bearing down and positioning. *Journal of Midwifery & Women's Health, 52*(3), 238–245.

Simkin, P., & O'Hara, M. (2002). Nonpharmacologic relief of pain during labor: Systematic reviews of five methods. *American Journal of Obstetrics and Gynecology, 186*(5), S131–S159.

Storton, S. (2007a). The Coalition for Improving Maternity Services: Evidence basis for the ten steps of mother-friendly care. Step 4: Provides the birthing woman with freedom of movement to walk, move, assume positions of her choice. *The Journal of Perinatal Education, 16*(Suppl. 1), 25S–27S.

Storton, S. (2007b). The Coalition for Improving Maternity Services: Evidence basis for the ten steps of mother-friendly care. Step 8: Encourages all mothers, families to touch, hold, breastfeed, care for their babies. *The Journal of Perinatal Education, 16*(Suppl. 1), 74S–76S.

Thacker, S. B., Stroup, D., & Chang, M. (2003). Continuous electronic heart rate monitoring for fetal assessment during labour (Cochrane review). In *The Cochrane Library, issue 3*. Oxford: Update Software.